



NURSE DELEGATION: CONSENT FOR DELEGATION OF TASKS

RESIDENT'S NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH (MM/DD/YYYY)		CLIENT ID NUMBER	
FACILITY NAME				FACILITY'S LICENSE NUMBER	
CLIENT/FACILITY'S ADDRESS		CITY		STATE	ZIP CODE
NAME OF FACILITY OWNER/MANAGER		TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS	
SETTING		RESIDENT DIAGNOSIS		ALLERGIES	
<input type="checkbox"/> Certified Community Residential Program for Developmentally Disabled <input type="checkbox"/> Licensed Adult Family Home <input type="checkbox"/> Licensed Boarding Home <input type="checkbox"/> Private Home					
HEALTH CARE PROVIDER NAME:					
NURSING CARE TASK(S) TO BE DELEGATED					
<input type="checkbox"/> MEDICATION ADMINISTRATION (ROUTE) <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <input type="checkbox"/> ORAL <input type="checkbox"/> GASTROSTOMY TUBE <input type="checkbox"/> TOPICAL (SKIN/NOSE/EAR/EYE) <input type="checkbox"/> VAGINAL SUPPOSITORY </div> <div> <input type="checkbox"/> RECTAL SUPPOSITORY <input type="checkbox"/> ENEMA <input type="checkbox"/> INHALATION <input type="checkbox"/> OTHER: _____ </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div> <input type="checkbox"/> OSTOMY CARE <input type="checkbox"/> URINARY CATHETERIZATION (CLEAN TECHNIQUE) <input type="checkbox"/> GASTROSTOMY FEEDING <input type="checkbox"/> OTHER: _____ </div> <div> <input type="checkbox"/> DRESSING CHANGE (CLEAN TECHNIQUE) <input type="checkbox"/> NEBULIZER/OXYGEN <input type="checkbox"/> BLOOD GLUCOSE MONITORING <input type="checkbox"/> OTHER: _____ </div> </div>					
<p>I have been informed of the delegated nursing care task(s), the expected results, the possible risks, and the nursing assistant(s) level of training.</p> <p>_____ I consent to Nursing Assistant(s) performing the nursing task(s) as directed by a Registered Nurse Delegator. <small>INITIAL</small></p> <p>_____ I have previously discussed the course of treatment that results in these nursing tasks with my health care provider and I <small>INITIAL</small> have consented to that treatment.</p> <p>VERBAL CONSENT (obtained from): _____ Date: _____ <i>(Written consent required within 30 days of verbal consent)</i></p>					
RESIDENT OR AUTHORIZED REPRESENTATIVE SIGNATURE		TELEPHONE NUMBER		DATE	
<p>My signature below indicates that I have assessed this resident and found this/her condition to be stable and predictable. I agree to assume responsibility and accountability for the delegated task(s) and perform the nursing supervision</p>					
RN SIGNATURE					
RN LICENSE NUMBER		TELEPHONE NUMBER		DATE:	